Foundation *for* Healthy Communities

July 27, 2018

Jeffrey Meyers
Commissioner
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers,

The Foundation for Healthy Communities appreciates the opportunity to share our comments in response to the request for public input regarding the Department's proposal for the State Opioid Response Funding Opportunity. Further, we appreciate the Department's comprehensive approach and focus on what can only be described as the most pressing public health challenge facing our state.

Given the magnitude of the opioid crisis all across New Hampshire, hospitals in all areas of the state need to have the capacity to provide access to treatment for people with Opioid Use Disorders (OUD) at all points of patient contact within their health care system.

Our Experience

The Foundation for Healthy Communities, under contract with the NH DHHS, began work in July 2016 to expand access to treatment for people with opioid use disorders. Projects were initiated at hospitals within New Hampshire to better connect emergency department patients with community treatment and services. Additional projects were initiated to embed medication assisted treatment (MAT) services in hospital affiliated primary care practices.

We have to date worked with 7 out of New Hampshire's 26 hospitals on emergency department projects to better connect patients with a primary or secondary diagnosis of an OUD to community treatments and services. Concurrently we have worked with 10 hospitals to achieve embedded MAT services in select primary care practices. Five of the seven hospitals working on emergency department projects are also working on MAT projects.

We have witnessed an increased readiness among New Hampshire hospitals to respond to the current crisis.

- Hospitals are working hard to help their staff feel prepared to offer services and to understand addiction as a remitting and relapsing chronic disease.
- Hospitals that engaged in both an emergency department project and embedded MAT services saw how protocols and policies in one project location within their system impacted events in another. Such hospitals are realizing the need to create access to OUD services at multiple points of patient contact.

- Hospitals increasingly want to prepare their care providers to have harm reduction conversations with patients knowing that such conversations are pathways into treatment.
- Hospitals not currently involved in the work are asking if there will be resources available to facilitate the system changes necessary in their organizations to support OUD services.

Recommendation for Increasing Access to MAT in New Hampshire

Conversations with hospitals illuminate the need to expand upon our current projects. Options for addressing significant geographic gaps as well as individual health system gaps are needed.

Patients with OUD are frequently hospitalized due to complications of the condition without also receiving treatment for the underlying disease of opioid addiction. These hospitalizations are missed opportunities leaving patients at high risk of future overdose. Hospitalizations are ideal times to start medication-assisted treatment for addiction and to connect patients to ongoing outpatient services. When hospitalized a person may be at one of the most vulnerable points regarding their Substance Use Disorder in that they are experiencing its impact most acutely on their health. This is an optimal time to assess readiness for change, conduct motivational interviewing, and provide a link to recovery treatments and services. Investments to date in New Hampshire hospitals have begun the necessary system changes. But there is more work to be done.

A project to expand access to treatment through New Hampshire hospitals could be constructed to simultaneously achieve the following:

- **Additional Phase I Work**: Invest in additional hospitals and healthcare systems not yet involved in Emergency Department "Bridge to Treatment" programs or primary care MAT projects. This work would focus on addressing geographic access to care gaps in our State.

- **Phase II Work:** Expand investment in health care systems in which initial investments have been made under the current contract to develop ED and/or Outpatient MAT services. This expanded investment would be to develop access to treatment at additional point(s) of patient contact within health care systems. Opportune points of access for expanded services include:
    - Inpatient MAT initiation including behavioral health and peer recovery services. Hospitalists will need training and supports to provide this service.
    - Emergency Department MAT inductions – Dispensing buprenorphine for 3 days from ED (or more through waivered providers). Implementation of this strategy is a complicated endeavor, but a potentially important point of access to treatment.
    - Creation of MAT bridge clinics as low threshold, on demand places for people to get basic treatment while awaiting access to an appropriate level of care. The goal of establishing Bridge clinics is to avoid patients becoming lost to care. As an on-demand service not intended for long term treatment, hospitals will face challenges to design, locate, and support such services.
    - Expansion of service capability for Mobile Integrated Health care teams that provide care in the patient's home.

- Expansion of Emergency Department and primary care MAT services beyond pilot sites to additional hospitals and/or practices within a health care system.

This work must continue to be guided by the following core principles:

- Chronic Care Model
- Patient Centered Approach
- Evidence Based Treatment
- Treatment Available on Demand
- Quality Standards Across Settings

Data Requirements for the SOR Grant opportunity seem impractical in the acute care setting. Regarding the GPRA requirement, if discharge is within days of intake, does it make sense to do more than the initial data collection? What sense does it make to complete the initial intake if a patient will not continue care within the system? A single state database/registry may be the best way to track people through their care. In the primary care setting, hospitals already collect many of the minimum required data elements. The requirement to use the separate GPRA tool will be a duplication of data gathering efforts already in place without easy transfer of that data. Significant work will need to be done to ensure that the data collection doesn't become a barrier to care.

In addition to the need to expand access to medication assisted treatment, hospitals continue to raise the following concerns for addressing the opioid crisis in our State:

- Workforce shortage issues are preventing hospitals from increasing access to treatment. The need is most acute regarding LDACs and MLDACs but also for other behavioral health providers and nurse care managers who are experienced and comfortable providing addiction medicine.
- A lack of recovery housing and transitional housing options is a huge barrier to helping people achieve and stay in recovery. Hospitals see a need for housing to support patients requiring intravenous antibiotics for 6 weeks. And more broadly they see the need to support anyone in recovery. Clinicians believe treating a patient for Endocarditis and then discharging them "home" to an unhealthy environment is not is the best interest of the patient's health and jeopardizes their long-term goals for recovery.

Thank you for your consideration of our comments. We would be happy to provide additional information or assistance in your planning. Please feel free to contact me or Rebecca Sky, Project Director, at (603) 415-4277.

Sincerely,

Peter Ames
Executive Director

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